TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

How to Become a Licensed Special Care Facility

Attached is an application packet for an Initial, Change of Ownership (CHOW), or Relocation License for a Special Care Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 125, Special Care Facility Licensing Rules, §125.12 Application and Issuance of Initial License. Information regarding licensure for health care facilities, including contact information for the zone office for your location is located on the department's website at www.dshs.state.tx.us/hfp.

The following documents, fees, and actions shall be completed and approved before a license will be issued:

Initial Application

- A license application form submitted no earlier than 90 calendar days prior to the projected opening date of the facility.
- A license fee of $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. *License fees are not refundable.*
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or www.dshs.state.tx.us/hfp/arch_review.shtm).
- The applicant or the applicant's representative shall attend a presurvey conference at the zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference (www.dshs.state.tx.us/hfp/contact.shtm).

Relocation Application

- A license application form submitted no earlier than 90 calendar days prior to the projected opening date of the facility.
- A license fee of $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. *License fees are not refundable.*
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or www.dshs.state.tx.us/hfp/arch_review.shtm).

Change of Ownership (CHOW) Application

- A license application form submitted prior to the date of the change of ownership or not later than 10 calendar days following the date of the change of ownership.
- A license fee of $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. *License fees are not refundable.*
- A copy of two completed Fire Safety Survey Report forms shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
- The applicant or the applicant's representative shall attend a presurvey conference at the zone office designated by the department. The designated zone office may waive the presurvey conference requirement for a Change of Ownership. Please contact the designated zone office to schedule the presurvey conference or to request a wavier (www.dshs.state.tx.us/hfp/contact.shtm).
- In addition to the documents required in §125.12 Application and Issuance of Initial License, the applicant shall include evidence (Bill of Sale, lease agreement, or legal/court document) of the Change of Ownership.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Hospital Licensing Section: phone (512) 834-6648, fax (512) 834-4514, email angela.arthur@dshs.state.tx.us or pamela.adams@dshs.state.tx.us.

Mailing address for applications with fees:
DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP
MAIL CODE 2003
P.O. BOX 149347
AUSTIN, TEXAS 78714-9347

Overnight mailing address for applications with fees;
DEPARTMENT OF STATE HEALTH SERVICES
FACILITY LICENSING GROUP
MAIL CODE 2003
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756

Revised 11/19/13

BUDGET: ZZ101
FUND: 141

Application for a License to Operate a Special Care Facility

☐ Initial
Projected date facility will open: _____ Architectural Project or Application #: _____

☐ Change of Ownership
Effective Date: _____ *(Signed Bill of Sale is required)* Current License #: _____

☐ Relocation
Projected Date Facility Will Open: _____ Current License #: _____
Architectural Project or Application #: _____

1. FACILITY INFORMATION:

Name the Special Care Facility will be doing business as (d/b/a):

_____

Street Address: _____
Street Number

_____
City/State/Zip County

Mailing Address: _____
Street or P.O. Box Number

_____
City/State/Zip

Telephone Number (include area code)

( ) _____
Leave blank if number is unknown at this time.

Fax Number (include area code)

( ) _____
Leave blank if number is unknown at this time.

2. OWNERSHIP INFORMATION:

_____
Name of Owner *(entity legally responsible for the operation of the facility, whether by lease or ownership)*

_____ _____
Mailing Address City/State/Zip

_____ _____ _____
Tax ID # or SS# Telephone Number E-Mail Address

Status: ☐ Profit ☐ Non-Profit

Type of Ownership:

☐ Sole Proprietor	☐ County	☐ Limited Liability Company
☐ Corporation	☐ City	☐ Hospital District
☐ Partnership	☐ City-County	☐ Hospital Authority
☐ LTD	☐ LP	☐ Other: _____

3. FACILITY DESIGNATION:

SPECIAL CARE FACILITY (SCF) - The term "special care facility" means an institution or establishment that provides a continuum of nursing or medical care or services primarily to persons with acquired immune deficiency syndrome or other terminal illnesses. The term includes a special residential care facility.

A special care facility's designation as a residential AIDS hospice must be approved by the Texas Department of State Health Services. A license holder or person may not use the word "hospice" in a title or description of a facility, organization, program, service provider, or services, or use any other words, letters, abbreviations, or insignia indicating or implying the person holds a license to provide hospice services under the Health and Safety Code, Chapter 142, Home and Community Support Services License. Notwithstanding Chapter 142, a special care facility licensed and issued a designation as a residential AIDS hospice under the Health and Safety Code, Chapter 248, may use the term "residential AIDS hospice" or a similar term or language in its title or in a description or representation of the facility if the similar term or language clearly identifies the facility as a facility regulated under Chapter 248 and clearly distinguishes the facility from a hospice regulated under Chapter 142. A special care facility shall meet §125.6(f)(12) if the special care facility provides residential AIDS hospice services.

To receive designation as a residential AIDS hospice, please check the appropriate box in this section and submit the documents listed in (a) and (b) as follows:

☐ Request designation as a residential AIDS Hospice ☐ No designation requested

(a) A written policy relating to the facility's organized program for the provision of residential AIDS hospice services, indicating palliative care and support, counseling, and bereavement services; and

(b) Documentation relating to the establishment and responsibilities of the facility's interdisciplinary team.

4. FIRE SAFETY SURVEY:

A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority. For change of ownership applications, a copy of two completed Fire Safety Survey Report forms shall be submitted; one report dated within the last 12 months and a second report dated within the last 13 to 24 months.

5. LICENSED BEDS AND FEES:

Total number of beds _____
** A change in the bed design capacity requires prior Department approval and possible fees.*

Total fee due is $70.00 per bed. The fee shall be no less than $600.00 or more than $5,000.00.

Amount paid: $_____ *(Fees paid to the Department are not refundable)*

6. OCCUPANCY CLASSIFICATIONS – for initial applicants only: *(Please select one below)*

A new facility shall be classified into one of the following two occupancy classifications:

☐ Limited Care Facility (LCF) – A LCF provides medical and nursing care, treatment and other services to residents who require staff attendance and supervision, including staff assistance to evacuate the facility. These residents are not able to participate in fire drills because they are either physically unable to respond to the fire alarm or they are incapable of following directions under emergency conditions.

☐ Residential Board and Care Facility (RBCF) – A RBCF provides medical and nursing care, treatment and other services for residents who do not require routine or continuous staff attendance and supervision, and are physically and mentally able to evacuate the facility. These residents must be able to participate in fire drills, be able to transfer and evacuate themselves and be capable of following directions under emergency conditions. A RBCF is further classified as either small or large. A small RBCF provides sleeping accommodations for up to 16 residents. A large RBCF provides sleeping accommodations for more than 16 residents.

7. SIGNATURE AND ATTESTATION:

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 125, Special Care Facilities Licensing Rules. I attest that all information contained in this application is true and correct. I attest that all copies submitted with the application are original copies or copies of the original documents.

_____	_____
Administrator Signature	Date Signed
_____	_____
Printed Name of Administrator	Title
_____	_____
Telephone Number	E-mail Address

8. CONTACT PERSON:

_____	_____
Name of the person completing this application	Title
_____	_____
Telephone Number	Email Address

Mailing address for applications with fees:
DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP
DELIVERY CODE 2835
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347

Overnight mailing address for applications with fees;
FACILITY LICENSING GROUP, MC 2003
DEPARTMENT OF STATE HEALTH SERVICES
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756

Name of SCF: _____ **BUDGET: ZZ101**
FUND: 141

OWNERSHIP ADDENDUM

Please complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary *(Social security numbers will be kept confidential under Government Code Section 552.147).*

The owner is a:

☐ **Partnership - List each general partner who is an individual.**

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

Print Name: _____ Social Security Number: _____/_____/_____

☐ **Corporation - List any individual who has an ownership interest of 25% or more in the corporation.**

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Regulatory Licensing Unit/Facility Licensing Group-Delivery Code 2835
P.O. Box 149347• Austin, Texas 78714-9347

Fire Safety Survey Report for Special Care Facilities

A copy of a Fire Safety Survey Report conducted within the last 12 months indicating approval by the local fire authority is required. For change of ownership applications, a copy of two completed Fire Safety Survey Report forms shall be submitted; one report dated within the last 12 months and a second report dated within the last 13 to 24 months.

Name of SCF: _____
License No.: _____ Physical Address: _____
Type of Building Construction_____ No. of Stories_____ Date of Inspection_____

EXITS

	Yes	No
1. Are exits and egress corridors and exits unobstructed?		
2. Is car parking at least 10 feet from exit door?		
3. Are exit signs operative and on emergency generator?		
4. Do exit doors swing outward and equipped with panic hardware?		

HEATING EQUIPMENT

	Yes	No
1. Are doors to furnace room equipped with automatic closers and are they kept closed?		
2. Are flues, pipes and steam lines--In good condition and properly insulated?		
3. Date of last boiler inspection: From _____ To_____		
4. Is there a gas cut-off outside the building?		

KITCHENS

	Yes	No
1. Is there a steel range hood over cooking equipment?		
2. Are the hood and listed filters clean?		
3. Is hood properly insulated and vented to open air?		
4. Is cooking equipment protected with a fire extinguisher?		
(a) Does discharge of automatic extinguisher sound the fire alarm signal or at least ring a local alarm?		
(b) Do nozzles cover all cooking surfaces?		
(c) Are gas or electricity automatically cut off?		
(d) Does automatic extinguisher have remote manual pull near egress?		
(e) Date of last automatic extinguisher inspection _____		
(f) Lights in hood have protective covers?		
5. Are doors to refrigeration machinery room kept closed?		
(a) Are motors and cooling coils clean?		
(b) Is room properly ventilated?		
(c) Are pressure relief valves and vents operative?		

LAUNDRY

	Yes	No
1. Are laundry doors to main building kept closed?		
2. Is tumbler free from lint and dust?		
3. Do electric devices and irons have operative automatic heat controls?		
4. Do safety pilot lights operate?		

LABORATORY

	Yes	No
1. Are flammable liquids stored properly?		
2. Are acids stored and handled properly?		
3. Are connections of Gas fired or open flame equipment in good condition?		
4. Are type and number of fire extinguishers proper for this area?		

OXYGEN & NITROUS OXIDE STORAGE

	Yes	No
1. Are Oxygen, Nitrous Oxide cylinders stored separately from other gases?		
(a) Are storerooms ventilated?		
(b) Are storerooms constructed as hazardous areas?		
(c) Are No Smoking signs and Nitrous Oxide warnings posted on storeroom doors?		
(d) Are cylinders stored to prevent tipping?		
(e) Are cylinders protected from the sun?		
(f) Are cylinders removed from steam pipes or radiators to prevent contact?		
(g) Is storage room equipped with automatic closed door and door kept closed?		
(h) Is light switch outside storage room 5 feet above floor, if in room?		
2. In operating and delivery rooms-- (a) Are explosive anesthetics used such as:Cyclopropane,Ethylene or Ether?		
(b) If above answer is yes, is conductive floor and other conductive equipment tested monthly?		
(c) Is a conductive shoe tester used in operating and delivery room areas?		

GENERATORS

Generator 1. Is it in good operating condition?	Yes	No
2. Is it automatic starting?		
3. Is generator tested underload monthly?		

WATER HEATERS

	Yes	No
1. Are water heaters properly vented?		
2. Are water heaters equipped with 100% safety pilots?		
3. Are water heaters equipped with pressure relief valves?		

INCINERATORS

	Yes	No
1. Is there an approved incinerator?		
2. Does incinerator appear in good repair?		

GENERAL

1. Check following locations where accumulations of waste paper, rubbish, old furniture, etc., are, and explain under "Remarks": attic, basement, furnace or boiler room, laundry, kitchen, sewing room, pharmacy, laboratory, maintenance shop, other locations.	Yes	No
2. Corridors free from storage of beds, linen carts, etc?		
3. Is space beneath stairs and elevator and dumbwaiter shafts free from storage of any materials?		
4. Are elevator, dumbwaiter, laundry and trash chute shafts made of fire resistant material?		
(a) Does each opening have a labeled frame with 1 1/2 B label fire door?		
(b) Are trash and laundry chutes sprinklered?		
5. Are covers on breaker panels and face plates in good condition?		
6. Are appliance cords in good condition?		
(a) Are appliance cords located as not to be subject to mechanical injury?		
(b) Is all permanent wiring in conduit?		
7. Are approved metal containers used for all oily waste, polishing or cleaning materials?		
8. Are ether and acetone kept in approved metal cans?		
9. Are all other combustible liquids kept in approved metal cans?		
10. Is refuse removed from premises or burned daily?		
11. Are grounds free from trash and weeds?		

If Code Violations are noted, has a Re-inspection been scheduled? YES _____ NO _____

PROTECTION

	Yes	No
1. Are all building sections of combustible and/or non-fireproof construction provided with automatic sprinklers?		
2. Where sprinklers are installed: (a) Are heads unobstructed?		
(b) Nothing is stored within 18" of heads (measured vertically)?		
(c) Sprinkler valves open?		
(d) Date of last fire sprinkler inspection _____		
(e) Are water flow indicating devices connected to fire alarm system and alarm bell?		
3. All employees know location of fire extinguishers and know how to use them?		
4. Date of last fire drill you attended _____		
5. Are fire alarm devices on each floor in each section of building operative?		
6. Are signs giving location of pull stations properly maintained?		
7. Are pull stations unobstructed and plainly marked?		
8. Date system last fire alarm tested _____		
9. Plan for evacuation of patients?		
10.Interior fire hose in good condition?		
11.Are waste containers in designated smoking areas, metal or listed approved materials?		
12.Are privacy curtains and drapes fire-retardant?		
13.(a) Does all the carpeting in corridors and exits pass the flame-spread test		
(b) or the radiant panel test?		
14. Are portable heaters used?		

THIS FACILITY MEETS LOCAL FIRE AND BUILDING CODES FOR A HEALTH CARE FACILITY

YES _____ NO _____

_____ _____

Signature of Local Fire Authority Date

_____

Printed Name of Local Fire Authority

Badge/License # _____

Local Fire Authority Phone Number _____

COMMENTS:

_____

_____

_____